Viral Hepatitis Case Report

Acute Hepatitis B

Michigan Department of Community Health

Communicable Disease and Immunization Division

Investigation Information

Investigation ID	Part of an outbreak?	Outbreak Name	Referral Date
	○ *Yes* ○ *No* ○ *Unknown*		mm/dd/yyyy

Investigation Status	Case Status
○ *New* ○ *Active* ○ *Completed* ○ *Superceded* ○ *Cancelled*	○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Status	Patient Status Date	Diagnosis Date	Onset Date
○ *Inpatient* ○ *Outpatient* ○ *Died*	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone	Ext.	Other Phone	Ext.
###-###-####		###-###-####	

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth	Age	Age Units
○ *Male* ○ *Female* ○ *Unknown*	mm/dd/yyyy		○ *Days* ○ *Months* ○ *Years*

Race

○ *Caucasian* ○ *African American* ○ *American Indian/Alaska Native* ○ *Hawaiian/Pacific Islander*
○ *Asian* ○ *Unknown* ○ *Other (Specify)*_____

Ethnicity	Worksites/School	Occupations/Grade
○ *Hispanic/Latino* ○ *Non-Hispanic/Latino* ○ *Unknown*		

Referral Information

Person Providing Referral

First	Last	Phone	Ext.	Email
		###-###-####		

Primary Physician

First	Last	Phone	Ext.	Email
		###-###-####		

Street Address

City	County	State	Zip

Hospital Information

Patient Hospitalized	Hospital	Hospital City	Hospital Record No.
○ Yes ○ No ○ Unknown			

Admission Date	Discharge Date	Days Hospitalized
mm/dd/yyyy	mm/dd/yyyy	

Clinical Information and Patient History

Place of Birth:	Did the patient die from hepatitis?	If yes, specify the date of death:
○ USA ○ Other_____	○ Yes ○ No ○ Unknown	mm/dd/yyyy

Reason for Testing:
(Check all that apply)

- ☐ *Symptoms of acute hepatitis*
- ☐ *Evaluation of elevated liver enzymes*
- ☐ *Screening of asymptomatic patient with reported risk factors*
- ☐ *Blood / Organ donor screening*
- ☐ *Screening of asymptomatic patient with no risk factors (e.g., patient requested)*
- ☐ *Follow-up testing for previous marker of viral hepatitis*
- ☐ *Prenatal screening*
- ☐ *Unknown*
- ☐ *Other*_____

Is the patient symptomatic?	Is or was the patient jaundiced?	Is or was the patient pregnant?	If yes, specify the due or delivery date:
○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	mm/dd/yyyy

Diagnosis:
(Check all that apply)

- ☐ *Acute hepatitis A*
- ☐ *Acute hepatitis B*
- ☐ *Acute hepatitis C*
- ☐ *Acute hepatitis E*
- ☐ *Chronic HBV infection*
- ☐ *HCV infection (chronic or resolved)*
- ☐ *Acute non-ABCD hepatitis*
- ☐ *Perinatal HBV infection*
- ☐ *Hepatitis Delta (co- or super-infection)*

Diagnostic Tests

Test Name	Result
	P=Positive N=Negative UNK=Unknown
Total antibody, hepatitis A virus [total anti-HAV]	
IgM antibody to hepatitis A virus [IgM anti-HAV]	
Hepatitis B surface antigen [HBsAg]	
Total antibody, hepatitis B core antigen [Total anti-HBc]	
IgM antibody, hepatitis B core antigen [IgM anti-HBc]	
Antibody to hepatitis D virus [anti-HDV]	
Antibody to hepatitis E virus [anti-HEV]	
Antibody to hepatitis C virus [anti-HCV]	
Supplemental anti-HCV assay [e.g., RIBA]	
HCV RNA [e.g., PCR]	

anti-HCV signal to cut-off ratio

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			mm/dd/yyyy
ALT (SGPT)			
AST (SGOT)			

Epidemiologic Information

Please answer the following questions for the time period 6 weeks - 6 months prior to the onset of symptoms:

Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?
○ *Yes* ○ *No* ○ *Unknown*

If yes, type of contact
○ *Sexual* ○ *Household (Non-sexual)* ○ *Other*_____

Did the patient inject drugs not prescribed by a doctor?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient use street drugs, but not inject?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient undergo hemodialysis?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient receive blood or blood products (transfusion)?
○ *Yes* ○ *No* ○ *Unknown*

If yes, when?
mm/dd/yyyy

Did the patient receive any IV infusions and/or injections in the outpatient setting?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient have other exposure to someone else's blood?
○ *Yes* ○ *No* ○ *Unknown*

If yes, specify:

Was the patient employed in a medical or dental field involving direct contact with human blood?
○ *Yes* ○ *No* ○ *Unknown*

If yes, frequency of direct blood contact:
○ *Frequent (several times weekly)* ○ *Infrequent*

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?
○ *Yes* ○ *No* ○ *Unknown*

If yes, frequency of direct blood contact:
○ *Frequent (several times weekly)* ○ *Infrequent*

Did the patient receive a tattoo?
○ *Yes* ○ *No* ○ *Unknown*

If yes, where was the tattooing performed?
(Check all that apply)
☐ *Commercial parlor/shop* ☐ *Correctional facility* ☐ *Other (specify)*_____

Did the patient have any part of their body pierced (other than ear)?
○ *Yes* ○ *No* ○ *Unknown*

If yes, where was the piercing performed?
(Check all that apply)
☐ *Commercial parlor/shop* ☐ *Correctional facility* ☐ *Other (specify)*_____

Did the patient have dental work or oral surgery?
○ *Yes* ○ *No* ○ *Unknown*

Did the patient have surgery? (other than oral surgery)
○ *Yes* ○ *No* ○ *Unknown*

Was the patient hospitalized?
○ *Yes* ○ *No* ○ *Unknown*

Was the patient a resident of a long term care facility?
○ *Yes* ○ *No* ○ *Unknown*

Was the patient incarcerated for longer than 24 hours?
○ *Yes* ○ *No* ○ *Unknown*

If yes, what type of facility?
(Check all that apply)
☐ *Jail* ☐ *Juvenile facility* ☐ *Prison*

During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?
○ *Yes* ○ *No* ○ *Unknown*

If yes, what year was the most recent incarceration?
yyyy

If yes, for how long?
(months)

Was the patient EVER treated for a sexually transmitted disease?
○ *Yes* ○ *No* ○ *Unknown*

If yes, in what year was the most recent treatment?
yyyy

In the 6 months prior to symptom onset, how many male sex partners did the patient have?
○ *0* ○ *1* ○ *2-5* ○ *>5* ○ *Unknown*

In the 6 months prior to symptom onset, how many female sex partners did the patient have?
○ *0* ○ *1* ○ *2-5* ○ *>5* ○ *Unknown*

Vaccine History

Did the patient ever receive hepatitis B vaccine?
○ *Yes* ○ *No* ○ *Unknown*

If yes, how many shots?
○ *1* ○ *2* ○ *3 or more*

In what year was the last shot received?
yyyy

Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?
○ *Yes* ○ *No* ○ *Unknown*

If yes, was the serum anti-HBs >= 10mIU/ml? (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')
○ *Yes* ○ *No* ○ *Unknown*

Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
mm/dd/yyyy		Code/Alternate Code/Text Result/Numeric Result		mm/dd/yyyy

Other Information

Local 1	**Local 2**

Name of Person interviewed	**Relationship to patient**	**Date of interview** mm/dd/yyyy

Submitted by:	**Date** mm/dd/yyyy	**Health Department**	**Phone Number** ###-###-####	**Ext.**

Comments or Additional Information